STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115287	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chulio Hills Health and Rehab	1170 Chulio Road Rome, GA 30161

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and review of the facility's policies titled Notification of Changes and Change in a Resident's Condition or Status, the facility failed to notify the responsible party and the Registered Dietician for one of 42 sampled residents (R)(R70) of significant changes in the resident's condition. This deficient practice had the potential to compromise the resident's nutritional management, overall care, and the responsible party's ability to participate in care planning and decision-making.Findings include:Review of the facility policy titled, Notification of Changes revised 1/1/2021, states The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Further review under the heading Circumstances requiring notification include: section 2. Significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental or psychosocial status. Section 3. Circumstances that require a need to alter treatment. This may include: a. New treatment.Review of the facility policy titled, Change in a Resident's Condition or Status revised October 2020, states under Policy Statement, that Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. Review of section 2. revealed A 'significant change' of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not 'self-limiting'); b. impacts more than one area of the resident's health status; c. requires interdisciplinary review and/or revision to the care plan. Further review of section 6 revealed Regardless of the resident's current mental or physical condition, a nurse or healthcare provider will inform the resident of any changes in his/her medical care or nursing treatments.Review of the electronic medical record (EMR) revealed resident R70 was admitted to the facility with pertinent diagnoses including but not limited to hypertension, unspecified symptoms and signs involving cognitive functions and awareness, dysphagia, pharyngoesophageal phase, hypotension, unspecified complication of kidney transplant, immunodeficiency, unspecified atrial fibrillation, chronic kidney disease stage 3, insomnia, cognitive communication deficit, and diagnosed with abnormal weight loss on 12/15/2025.Review of R70 quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 8, which indicated that R70 had moderate cognitive impairment. Section GG, functional abilities and goals, revealed no impairments, independent to supervision/touching assistance.Review of R70's care plan dated 7/31/2025 indicated a problem of therapeutic diet to maintain optimal health and nutrition. Diet order: regular diet. Goals included but not limited to adequate nutritional intake while complying with diet restrictions. Intervention included but not limited to arrange dental consult if needed; monitor for tolerance and acceptance of ordered diet; monitor meal intake; obtain and monitor pertinent labs; obtain and monitor weights as ordered or per protocol; ST (Speech Therapy) consult as needed. Review of the Physician's Orders for R70 included but was not limited to:Order dated 8/4/2025 for Regular diet, Regular texture, Thin consistency.Order dated 11/18/2025 for ReadyCare 2.0 or equivalent 2.0 calorie product: two times a day for recent weight loss, RD (Registered Dietician) consult. 90 mL (milliliters) per serving. May substitute equivalent 2.0 Cal product.Order dated 12/15/2025 for Remeron Tablet 15 mg (milligrams) (Mirtazapine): Give 0.5 tablet by mouth at bedtime related to Abnormal Weight Loss. Dosage is 7.5 mg. Review of R70's nutrition intake log revealed that R70 either refused meals or consumed less than 25% (percent) of meals on 12/17/2025, 12/16/2025, 12/15/2025, 12/13/2025, 12/11/2025, and 12/10/2025.Review of R70's medication administration record for December 2025 revealed multiple medication refusals. Refusals occurred at the 0800 (8:00 am) medication administration time on 12/16/2025, 12/15/2025, 12/10/2025, 12/9/2025, 12/8/2025, and 12/7/2025. Additional refusals occurred at the 1700 (5:00 pm) medication administration time on 12/16/2025, 12/15/2025, 12/10/2025, 12/9/2025, and 12/7/2025.Review of R70's progress notes revealed no documentation indicating that R70's representative or Registered Dietician (RD) were informed of the significant change in status related to R70's refusal of meals and medications.Interview and observation on 12/16/2025 at 10:41 am with R70 revealed that he had lost weight. Follow-up interview and observation at 1:20 pm revealed R70 had not touched his lunch tray, did not consume any portion of the lunch.Interview and observation on 12/17/2025 at 10:40 am with R70 revealed resident had not consumed any breakfast that morning but did consume a Boost

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, review of the Resident Assessment Instrument (RAI) Manual, and review of the facility policy titled Maintaining Minimum Data Set (MDS) Assessments, the facility failed to accurately complete the Quarterly MDS assessment by not including hospice services for one of twelve residents (R) (R7) on hospice.Findings include:Review of the policy titled, Maintaining Minimum Data Set (MDS) Assessments revised November 2019, revealed the policy addressed maintenance and retention of MDS records but did not include guidance to ensure accurate coding of services, including hospice services, on Quarterly MDS assessments.Review of the electronic medical record (EMR) revealed R7 was admitted into hospice services on 6/11/2025.Review of R7 quarterly MDS assessment dated [DATE] revealed that section O, Special Treatments, Procedures, and Programs, did not indicate hospice services.Interview on 12/16/2025 at 12:53 pm with MDS Registered Nurse (RN) LL revealed that hospice services for resident R7 were not coded on the Quarterly MDS. She stated that she had since opened a modification and corrected the assessment. She further stated that accurate MDS coding was important because it affected the resident's care plan, and if the MDS was not accurate, the care plan was also not accurate.Interview on 12/18/2025 at 1:50 pm with the Director of Nursing (DON) revealed that the MDS must be accurate, as it reflected the resident's care plan and directs care tasks, and that the care plan was the foundation for all aspects of resident care.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and review of the facility's policy titled Comprehensive Care Plan, the facility failed to develop and implement comprehensive, person-centered care plan for one of 42 sampled residents (R) (R47). Specifically, the facility failed to develop and implement care plan interventions related to oxygen (O2) administration. This deficient practice had the potential to place the resident at risk for inadequate monitoring and improper oxygen administration, which could compromise the resident's health and safety.Findings include:Review of the facility's policy titled Comprehensive Care Plan, revised January 2021, revealed under the section 2, .All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care.Record review of the Electronic Medical Record (EMR) revealed R47 was admitted with pertinent diagnoses including but not limited to Alzheimer's Disease, chronic obstructive pulmonary disease (COPD), respiratory failure, asthma, acute respiratory failure with hypoxia, hypertensive heart disease with heart failure, and iron deficiency anemia.Review of R47 quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 5, which indicated R47 was severely cognitively impaired. Section I listed the following respiratory diagnoses: respiratory failure, asthma/chronic obstructive pulmonary disease (COPD) or chronic lung disease, and acute respiratory failure with hypoxia. Section O revealed oxygen therapy.Review of R47's care plan dated 11/10/2025 revealed no problems or interventions related to respiratory conditions or oxygen use, despite the MDS indicating both respiratory diagnoses and oxygen administration.Review of the Physician's Orders for R47 included but was not limited to: Order dated 11/10/2025 for administer oxygen at 2 L/min per nasal cannula (NC) as needed.Order dated 11/15/2025 for change O2 tubing weekly when oxygen is in use.Order dated 11/15/2025 for clean oxygen concentrator filter weekly when oxygen is in use.Order dated 11/10/2025 for elevate head of bed related to shortness of breath when lying flat.Observation and interview on 12/16/2025 at 11:08 am revealed that R47 had an oxygen concentrator next to the head of the bed but was unsure how frequently she is supposed to receive oxygen. Observation and interview on 12/17/2025 at 10:42 am revealed R47 was wearing her O2 via NC and the O2 concentrator was running at the setting of 2 Liters Per Minute (LPM).Observation and interview on 12/18/2025 at 12:29 pm revealed R47 was wearing her O2 via NC and the O2 concentrator was running at the setting of 2 LPM.Interview on 12/16/2025 at 12:53 pm with MDS Registered Nurse (RN) LL confirmed that R47 care plan was missing information regarding oxygen use and respiratory diagnoses. Stated that she reviewed care plans daily and this one was missed. She further stated that accurate MDS coding was important because it affected the resident's care plan, and if the MDS was not accurate, the care plan was also not accurate.Interview on 12/18/2025 at 1:50 pm with the Director of Nursing (DON) revealed that the MDS must be accurate, as it reflected the resident's care plan and directed care tasks, and that the care plan was the foundation for all aspects of resident care.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility policy titled, Wound Management Program Pressure Ulcers, the facility failed to ensure that appropriate pressure ulcer prevention interventions were initiated, implemented, monitored, and documented for one of 15 residents (R) (R96) who were identified as being at risk for pressure injuries and who developed a pressure ulcer during the facility stay. This deficient practice had the potential to cause actual harm, including the development and worsening of pressure ulcers, delayed wound healing, increased risk for infection, pain, and decline in skin integrity. Findings include:Review of the policy titled, Wound Management Program Pressure Ulcers revised October 2023 states that: A resident that enters our facility without pressure ulcers will not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. Review of section 4 states: Every resident will be assessed upon admission or re-admission using the Braden weekly x 4 weeks. This assessment will be updated if a resident who does not have pressure ulcers develops a pressure ulcer. Review of section 9 states: All residents will have a head to toe skin observation done with showers by the C. N.A. (Certified Nursing Assistant) and Weekly Skin Assessments/Observations will be done by the licensed nurses in the electronic medical record. Further review of section 12. A. states: All bed bound/chair bound residents will be positioned every 1-2 hours as determined by the interdisciplinary team.Review of the electronic medical record (EMR) revealed R96 was admitted to the facility on [DATE] for five days of Respite care via Hearth Hospice and pertinent diagnoses including but was not limited to morbid obesity (370 pounds), acute respiratory failure with hypercapnia, chronic diastolic heart failure, obstructive sleep apnea, atherosclerotic heart disease, peripheral vascular disease (PVD), hereditary spastic paraplegia, polyneuropathy, ataxia, lymphedema, and autism.R96 did not have a formal Minimum Data Set (MDS) completed during the respite stay; however, relevant information including cognitive status, functional status, and care needs, were obtained from progress notes and nursing documentation. Brief Interview for Mental Status (BIMS) could not be completed, as R96 was unable to respond to the interview, indicating severe cognitive impairment (score 0.0). Section GG, functional status, revealed R96 required extensive/maximal assistance for all activities of daily living (ADLs). R96 had impairments in both upper and lower extremities. Bed mobility required assistance for rolling left and right. Sit-to-lying and lying-to-sitting on the side of the bed were not attempted due to medical condition or safety concerns. Sit-to-stand, chair/bed-to-chair transfers, toilet transfers, and tub/shower transfers were not attempted. R96 did not use a wheelchair or scooter, and ambulation, including walking on flat or uneven surfaces or climbing steps, was not attempted. Review of R96 care plan dated 12/6/2024 indicated the resident was bed-bound, and transfers or mechanical lifts were not utilized during the 5-day respite stay per family request due to fear of mechanical lifts related to Autism. Staff provided total assistance with all self-care activities, including eating, oral hygiene, toileting, bathing (partial or sponge bath), dressing (upper and lower body), and putting on or taking off footwear, while encouraging the use of the call light for assistance. The resident was fully dependent for all bed mobility, with transfers avoided in accordance with the care plan. Staff were instructed to perform skin observations during ADL care and bathing, monitoring for redness, open areas, cuts, bruises, or other changes, and to report any findings to licensed nursing staff. Care plan interventions also addressed peripheral vascular disease, instructing staff to monitor for edema, injury, infection, or ulcers and provide medications or elevation as ordered. Incontinence care included frequent checks, prompt cleansing after episodes, and maintaining dignity while keeping the skin clean and dry. Staff were directed to follow facility protocols for skin care, encourage nutrition and hydration to promote skin health, use caution during repositioning to prevent injury, explain procedures before care, and respect the resident's right to refuse care.Review of the Physician's Orders for R96 included but was not limited to:Order dated 12/11/2024, Cleanse (UNSTAGEABLE) Pressure Ulcer to Left Heel with Normal Saline, Pat Dry, Apply Skin Prep. Cover with Foam dressing every day shift Monday, Wednesday, Friday and PRN for soiling and displacement.Order dated 12/11/2024, Discharge skin assessment to be completed on day of discharge.Order dated 12/6/2024, admission skin assessment to be completed on admission. Review of R96 Braden Scale evaluation (wound evaluation) completed on admission [DATE], with a score of 15, indicated R96 was at risk for pressure injuries.Review of R96 skin assessment on 12/6/2024, admission, noted skin is dry and intact. On 12/10/2024, the skin assessment revealed right heel-blister; sacrum-redness; other-bottom redness; RLE (right lower extremity) and LLE (left

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, record review, and a review of facility policy titled, Oxygen Concentrator, the facility failed to ensure that one resident (R) R89 was administered oxygen therapy in accordance with the physician's orders. Findings include:Review of facility policy titled Oxygen Administration, revised date 3/5/2024, revealed in section 4. Use of the Concentrator a. When oxygen is ordered for a resident, the nurse will be responsible for initiating use, labeling tubing to include initials and date, and ensure all orders for filter cleaning and humidification into the Computer Order Entry System (CPOE). m. Check the resident's oxygen saturations as ordered by physician. Troubleshoot the concentrator if saturation do not correlate with the resident's clinical presentation.A review of the clinical record for R19 revealed she was admitted to the facility with diagnoses including but not limited to multiple encounter for prophylactic immunotherapy for respiratory syncytial virus (RSV), respiratory failure, unspecified with hypoxia, and pneumonia, Unspecified Organism. The resident's most recent Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score was coded as 15, which indicated cognitive impairment.A review of the care plan initiated on 11/19/2025 and revised on 09/3/2025 revealed The resident has altered respiratory status r/t respiratory failure. Further interventions indicate OXYGEN SETTINGS: O2 via nasal cannula at 2 Liters per Minute (LPM) continuously.An observation conducted on 12/16/2025, at 11:23 am, indicated that the oxygen levels were recorded between 1.5 and 2, yet remained below the 2 liters (L) being administered through the Nasal Cannula (NC).An observation made on 12/17/ 2025 at 4:47 pm indicated that the oxygen (O2) levels were consistent with the previous readings while administering less than 2 liters through the NC.Interview and Observation on 12/17/2025 at 5:10 pm, Licensed Practical Nurse (LPN) MM accompanied the surveyor to the residents' room and verified that the O2 concentrator's flow rate was set below 2 LPM, as delivered through the NC, which was slightly lower than the physician's orders. LPN MM also confirmed that while conducting her rounds this morning, she observed the concentrator.Interview with Assistant Director of Nursing (ADON) 12/18/2025 at 10:42 am, confirmed R89's order was for O2 at 2 LPM and the concentrator was between 1.5 and 2 LPM, but the marker should be placed on the line. Given that the resident has congestive heart failure (CHF), her inaccurate saturation levels may induce anxiety, leading to shortness of breath. The ADON clarified that if she were to establish the saturation levels, she would make certain that the concentrator was set at eye level, although she could not confirm whether this was in accordance with policy.An interview conducted on 12/18/2025 at 2:10 pm with the Director of Nursing (DON) indicated that nurses should monitor concentrators and make adjustments or corrections according to physician orders. The DON noted that inaccurate reading could exacerbate symptoms and extend the duration of R89' pneumonia.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, staff interviews, a review of the facility policy titled, Specific Medication Administration Procedures, and a review of the manufacturer's instructions for steroid inhalers, the facility failed to maintain a medication error rate below five percent. An observed medication error rate of 5.71% was identified during 35 medication administration opportunities. Specifically, medication administration errors were observed during two of five medication passes, in which nursing staff failed to instruct residents to rinse and spit after administration of corticosteroid inhalers. This deficient practice has the potential to increase the risk of medication-related side effects.Findings include:Review of the facility's policy titled Specific Medication Administration Procedures, last reviewed on 4/1/2016, revealed the Policy section Q: For steroid inhalers, provide the resident with a cup of water and instruct him/her to rinse the mouth and spit the water back into the cup.Review of the manufacturer's instructions How to use your ELLIPTA inhaler it reads .Rinse your mouth with water after use. Be sure not to swallow the water.Review of the manufacturer's instructions for use for Arnuity Ellipta revealed the following directive: . Step 6: Rinse your mouth. Rinse your mouth with water after you have used the inhaler and spit the water out. Do not swallow the water.On 12/17/2025 at 8:15 am, Licensed Practical Nurse (LPN) AA was observed performing a medication pass for Resident R74. During the medication pass, LPN AA administered Breo Ellipta Inhaler, (a medication used to treat chronic obstructive pulmonary disease (COPD) that contains a corticosteroid.) However, the nurse did not offer the resident water to rinse their mouth and spit after use.In an interview with LPN AA following the observation, the surveyor asked whether any additional action should have been taken after administering the inhaler. LPN AA appeared uncertain. The surveyor asked whether the inhaler was a steroid and whether the resident should have been offered water and instructed to rinse the mouth after use. LPN AA responded, I should have, but I only placed a cup of water on the bedside table. A bright green note on the inhaler box stated, Rinse mouth thoroughly after each use.On 12/17/2025 at 8:45 am, LPN BB was observed performing a medication pass for R47. During the medication pass, LPN BB administered Arnuity Ellipta Inhaler, (a medication used to treat asthma that contains a corticosteroid.) However, the nurse did not offer the resident water to rinse their mouth and spit after use.In an interview with LPN BB following the observation, the surveyor asked whether the inhaler was a steroid and whether the resident should have been instructed to rinse the mouth after use. LPN BB acknowledged that mouth rinsing should have been offered and stated that she forgot to do so. The inhaler box was observed to have a bright green note stating, Rinse mouth thoroughly after each use.In an interview with the Pharmacist (C) on 12/17/2025 at 11:34 am, the Pharmacist stated that rinsing the mouth after use is needed for inhaled corticosteroids to prevent oral candidiasis. The pharmacist further stated that nursing staff were alerted to this requirement through a bright label placed on the medication box indicating rinse mouth after use. In a joint interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 12/17/2025 at 2:45 pm, they stated that mouth rinsing after use was recommended for steroid inhalers to prevent thrush. They further stated that nursing staff were aware of this requirement because it was indicated on the medication packaging. The ADON stated that she expect nursing staff to encourage residents to rinse and spit after inhaler use by providing a cup of water.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observations, staff and resident interviews, record review, and review of the facility's policy titled, Adaptive Equipment the facility failed to ensure one of eight residents (R) (R88) received a feeding adaptive equipment device at each meal. This failure had the potential to affect the nutritional independence of R88. Findings include:Review of facility policy, Adaptive Equipment last revised March 2024 documented in Procedures: . 3. The resident will be assessed as needed for appropriateness of the adaptive equipment and make changes as needed to help facilitate independence. Interview on 12/16/2025 at 10:28 am with R88 revealed that her feeding adaptive equipment was usually not on her tray, and that, due to her health/stroke, she has great difficulty eating without it.Observation on 12/16/2025 at 12:30 pm revealed no feeding adaptive equipment served on R88's tray. The menu card revealed in bold letters, Built-Up Utensil (1 Each) under Preferences. R88 indicated that she had to ask the CNA (Certified Nursing Assistant) to get it for her. She indicated the CNA did get it from the kitchen, but by that time the food was cold. Observation on 12/17/2025 at 12:10 pm revealed tray being delivered to R88's room with no assistive device. R88 displayed her regular utensils only and the meal card that indicated a feeding adaptive equipment preference.Review of the Order Listing Report dated 12/18/2025 revealed this report listed R88 with an order summary of Built up handled utensils for all meals. Interview on 12/18/2025 at 9:43 am with the Dietary Manager regarding feeding adaptive equipment revealed that residents with orders were to be getting their devices at every meal, and that they had enough of the devices. The physician did make orders for these devices. We can't put the devices on the plate without the order. Interview on 12/18/2025 at 10:51am with the Administrator revealed he expected the residents to get their utensils. If there's a physician's order, then they needed to have the feeding devices.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and review of the facility policies titled Infection Prevention and Control Program, and Handwashing/Hand Hygiene, the facility failed to maintain appropriate infection control practices. Specifically, a nurse was observed using a box of gloves during wound care and removing it from the resident's room for use with other residents, a staff member failed to adhere to Transmission-Based Precautions by not wearing appropriate PPE (Personal Protective Equipment) and did not perform hand hygiene when entering/exiting an isolation room, and the facility failed to ensure the Infection Prevention and Control Program policy was reviewed and updated annually. These failures had the potential to contribute to the transmission of infectious organisms among residents, staff, and visitors Findings include:Review of the facility's policy titled, Infection Prevention and Control Program, revised October 2018, section 11, Prevention of Infection, subsection a. (3) revealed educating staff and ensuring that they adhere to proper techniques and procedures. Further review of section 6, Policies and Procedures subsection c. revealed, The infection prevention and control committee, Medical Director, Director of Nursing Services, and other key clinical and administrative staff review the infection control policies at least annually. Review of the facility's policy titled, Handwashing/Hand Hygiene, revised February 2021, section 7, Use an alcohol-based hand rub containing at least 62% (percent) alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: n. Before and after entering isolation precaution settings.Review of the facility policy titled Infection Prevention and Control Program, last revised October 2018, revealed that it has not been reviewed or revised since that date, indicating noncompliance with the facility's policy requirement for annual review as outlined in section (6.c).Observation made on 12/17/2025 at 9:57 am, revealed Wound/Treatment Licensed Practical Nurse (LPN) EE performing wound care. The nurse brought a full box of gloves into the resident's room and placed it on the overbed table. Gloves were removed from the box during the procedure, and upon completion, the nurse carried the same box out of the room.Observation made on 12/17/2025 at 4:25 pm, revealed Maintenance Assistant HH exiting room [ROOM NUMBER]-P, which had signage posted with Contact Precautions for candida auris. The door was wide open, and he was observed coming out of the resident's bathroom without wearing PPE (gown or gloves) and without performing hand hygiene after exiting the isolation room.Interview on 12/17/2025 at 9:57 am with Wound/Treatment LPN EE revealed that when asked about the box of gloves, the nurse stated she intended to use it for wound care on another resident. When asked about infection control concerns, the nurse acknowledged that the box should have remained in the resident's room, as removing it could create a contamination risk for other residents.Interview on 12/17/2025 at 4:25 pm with Maintenance Assistance HH when questioned about the Contact Isolation Precautions and posted signs, he initially stated, I don't know anything about that, and began to walk away. After being asked to review the signs, he stated, I guess I was supposed to wear a gown and gloves, probably because of some infection, and acknowledged he had not received Infection Prevention training. When questioned about hand hygiene, he stated he intended to perform it.Interview on 12/18/2025 at 1:23 pm with Infection Preventionist/Unit Manager revealed that everyone entering a Contact Precautions room should wear full PPE, as the resident is in isolation and could potentially transmit infection to others. She further stated that all staff must receive proper training and perform hand hygiene at all times, regardless of isolation status. Regarding wound care, she explained that if a box of gloves was taken into a resident's room and used, it must remain in that room, as removing it would be considered contaminated.Interview on 12/18/2025 at 1:50 pm with Director of Nursing (DON) revealed that all staff, regardless of position, required to observe and follow Contact Precautions and use appropriate PPE to protect themselves and residents and prevent transmission to other residents. She further stated that staff must perform hand hygiene and that a box of gloves used during wound care should not be removed from the resident's room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115287	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chulio Hills Health and Rehab	1170 Chulio Road Rome, GA 30161

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations, staff interviews, and review of the facility's policy titled, Cleaning and Disinfection of Environmental Surface, the facility failed to provide a safe, functional, sanitary, and comfortable environment throughout the facility on the 100, 200, and 300 Halls, the common area near the nurse station, and lobby, related to delay in repairing damaged ceilings tiles and dust-like vents.Findings include:The policy titled Cleaning and Disinfection of Environmental Surface revised date October 2018, revealed under number 10. Environmental surfaces will be disinfected (or cleaned) on a regular basis, when spills occur, and when these surfaces are visibly soiled. 14. Horizontal surfaces will be wet dusted regularly using clean cloths moistened with EPA (Environmental Protection Agency)-registered hospital disinfectant.An observation conducted on 12/16/2025, at 9:33 am, during the initial tour, indicated the presence of dust-like accumulation on the ceiling vents and a broken sheetrock ceiling tile.On 12/18/2025, at 1:05 pm, an interview and observation were conducted with the Administrator, Assistant Director of Nursing (ADON), and Director of Nursing (DON) confirmed the presence of a dust-like accumulation on the vents situated near the nurse station along the pathway to the common areas of the dining room and front entrance. Each individual acknowledged that this buildup could potentially provoke allergic reactions, shortness of breath, coughing, itching, and respiratory distress in residents with pre-existing respiratory conditions. Observations revealed buildup on each vent across all three halls and common areas.An interview conducted on 12/18/2025, at 2:38 pm, with the Maintenance Director indicated that cleaning was monitored through TELS (maintenance on line reporting system) and was scheduled to occur every three months. The Maintenance Director affirmed that he performed daily rounds; however, he had not observed any accumulation of dust resembling a ventilation issue.